Statement of Employer Payments

Date:		In Reply, Refer to Case No:	
Prime:			
Subcontractor:			
PROJECT NAME:			
PROJECT CONTRACT NO.:		County/location:	

HEALTH AND WELFARE

NAME OF PLAN _____ Address, City and Zip _____

ADMINISTRATOR _____ Address, City and Zip _____

CLASSIFICATION(S) USED	CONTRIBUTION PER CLASSIFICATION PER HOUR

CONTRIBUTIONS: WEEKLY_____ MONTHLY_____ QUARTERLY_____ ANNUALLY_____

PENSION

NAME OF PLAN _____ Address, City and Zip _____

ADMINISTRATOR _____ Address, City and Zip _____

CLASSIFICATION(S) USED	CONTRIBUTION PER CLASSIFICATION PER HOUR

CONTRIBUTIONS: WEEKLY_____ MONTHLY_____ QUARTERLY_____ ANNUALLY_____

VACATION/HOLIDAY

NAME OF PLAN _____ Address, City and Zip _____

ADMINISTRATOR _____ Address, City and Zip _____

CLASSIFICATION(S) USED	CONTRIBUTION PER CLASSIFICATION PER HOUR

CONTRIBUTIONS: WEEKLY_____ MONTHLY_____ QUARTERLY_____ ANNUALLY_____

TRAINING

NAME OF PLAN _____ Address, City and Zip _____

ADMINISTRATOR _____ Address, City and Zip _____

CLASSIFICATION(S) USED	CONTRIBUTION PER CLASSIFICATION PER HOUR

CONTRIBUTIONS: WEEKLY_____ MONTHLY_____ QUARTERLY_____ ANNUALLY_____

IF YOU USE OTHER PLANS NOT LISTED ABOVE, YOU MAY USE THE BACK OF THIS FORM TO PROVIDE THIS ADDITIONAL INFORMATION